STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366471	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Broadview Heights	1201 Akins Road Broadview Heights, OH 44147

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility policy, and review of hospital records, the facility failed to properly assess and monitor Resident #43 and Resident #59's urinary condition to timely identify and treat signs and symptoms of a urinary tract infection. Actual Harm occurred on 06/13/25 at 9:07 A.M to Resident #59 when the resident's care planned interventions to monitor urine output and orders to irrigate the catheter were not implemented, symptoms of a UTI were not timely identified, and the resident presented with an emesis, tachycardia with a heart rate of 143, complaints of being cold, had a large diarrhea bowel movement and chills. On 06/13/25 at 1:12 P.M. Resident #59 requested to be transported to the hospital after she started having difficulty breathing and her oxygen saturations were 87 to 88 percent. Resident #59 was transported to the hospital emergency department (ED) and was found to have septic shock secondary to catheter associated urinary tract infection (CAUTI) and acute kidney injury. Resident #59 had positive urine cultures for enterococcus and positive urine and blood cultures for Citrobacter. Resident #59 was treated with vasopressors and broad spectrum antibiotics. This affected two residents (Resident's #43 and #59) out of three residents reviewed for urinary tract infections. The facility census was 58.Findings include:1. Review of Resident #59's closed medical record revealed an admission date of 11/14/24 and diagnoses included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypercapnia, obstructive and reflux uropathy, and retention of urine. Resident #59 was discharged from the facility on 07/11/25.Review of Resident #59's care plan dated 11/19/24 included Resident #59 had bowel and bladder incontinence, and required catheter care. Resident #59 would establish an individual bowel, bladder routine. Interventions initiated on 06/29/25 included to monitor intake and output; catheter care per policy. Review of Resident #59's care plan dated 12/19/24 and revised 07/24/25 included Resident #59 had an 18 French, five milliliter (ml) balloon indwelling catheter related to obstructive uropathy. Resident #59 would be, remain free from catheter related trauma through the review date. Interventions included monitor and document intake and output as per facility policy; monitor, record, report to the physician signs and symptoms of UTI (urinary tract infection) including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.Review of Resident #59's care plan dated 12/19/24 and revised on 07/24/25 included Resident #59 had hypertension. Resident #59 would remain free from signs and symptoms of hypertension through the review date. Interventions included to monitor, document abnormalities for urinary output and report significant changes to the physician.Review of Resident #59's medical record including progress notes, Medication Administration Record and Treatment Administration Record dated 12/19/24 through 06/29/25 did not reveal evidence Resident #59's urine outputs were monitored and recorded.Review of Resident #59's progress notes dated 12/28/24 at 5:28 P.M. revealed an aide reported to the nurse concerns Resident #59's urine was dark in color. The nurse observed Resident #59's urine was dark in color and Resident #59 stated this happened when she needed water. Resident #59 requested ice, cranberry juice and water. No blood was observed in Resident #59's urine at this time.Review of Resident #59's progress notes dated 12/30/24 at 8:49 A.M. revealed new orders to encourage fluids in place at this time.Review of Resident #59's progress notes dated 12/28/24 through 01/27/25 did not reveal evidence further observations of Resident #59's urine were made including consistency, color and urine output amount.Review of Resident #59's progress notes dated 01/27/25 at 4:56 A.M. revealed Resident #59 called the nurse into her room. Resident #59 was screaming out in pain saying her catheter was not working right. An unsuccessful attempt was made to flush the catheter, the catheter was removed and an unsuccessful attempt was made to insert a new catheter due to resistance. No urine output returned during the attempt to place a new catheter. Resident #59's abdomen was noticeably distended and Resident #59 was in excruciating pain. Resident #59's on call Nurse Practitioner was contacted and Resident #59 was transported via 911 to the ED at 4:45 A.M. Resident #59's daughter was notified via voicemail.Review of Resident #59's hospital ED Provider notes dated 01/27/25 at 5:11 A.M. revealed Resident #59 was transported to the ED for evaluation of her indwelling catheter becoming obstructed and nursing staff at the facility were unable to replace the catheter. Apparently there was blood in it and it did not appear to be draining. Onset of symptoms was several hours ago and Resident #59 was having little urine output and more discomfort. Resident #59 has had catheter in place for several months

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility policy and review of hospital records the facility failed to ensure Resident #59's care planned interventions were implemented and physician orders were followed for oxygen therapy. This affected one resident (Resident #59) out of three residents reviewed for oxygen therapy. The facility census was 58. Findings include:Review of Resident #59's closed medical record revealed an admission date of 11/14/24 and diagnoses included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypercapnia, obstructive and reflux uropathy, and retention of urine. Resident #59 had a left pneumonectomy in December, 1989. Resident #59 was discharged from the facility on 07/11/25.Review of Resident #59's care plan dated 12/19/24 and revised on 07/24/25 (Resident #59 was discharged from the facility on 07/11/25) revealed Resident #59 had an altered respiratory status and difficulty breathing related to COPD (chronic obstructive pulmonary disease) and chronic respiratory failure. Resident #59 would maintain a normal breathing pattern as evidenced by normal respirations, normal skin color and a regular respiratory rate, pattern through the review date of 09/14/25. Interventions included to administer oxygen as ordered; auto BIPAP (Bilevel Positive Airway Pressure, a non-invasive ventilation technique that provided respiratory support by delivering two different levels of air pressure during inhalation and exhalation) 20/10 cmH2O (centimeters of water and is a unit of pressure) with 3L O2 (three liters of oxygen) at bedtime and as needed; observe for changes in orientation, increased restlessness, anxiety and air hunger; observe for signs and symptoms of respiratory distress (including increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, skin color changes to blue-gray) and report to the physician as needed Review of Resident #59's medical record including progress notes, MAR and TAR dated 03/04/25 revealed Resident #59 refused her BIPAP, but no reason for refusing the BIPAP was documented in her medical record.Review of Resident #59's medical record including progress notes, Medication Administration Records (MAR) and Treatment Administration Records (TAR) dated 03/05/25 through 06/23/25 did not reveal evidence Resident #59 refused her BiPAP therapy.Review of Resident #59's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #59 was cognitively intact. Resident #59 required partial to moderate assistance with toileting hygiene, bathing, and upper body dressing. Resident #59 required supervision or touching assistance with personal hygiene. Resident #59 required substantial to maximal assistance to roll left and right and return to lying on her back on the bed. Resident #59 had an indwelling catheter and was frequently incontinent of bowel. Resident #59 did not reject care during the seven-day assessment look-back period. Resident #59 used oxygen therapy.Review of Resident #59's hospital Discharge Instructions for a hospital stay dated 06/13/25 through 06/22/25 included Resident #59's hospital problems as of 06/22/25 included the principal problem was septic shock secondary to CAUTI (catheter associated urinary tract infection) and citrobacter bacteremia (resolved) and other problems included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia and hypercapnia, chronic indwelling catheter and obstructive and reflux uropathy. Resident #59's condition at discharge was improved and symptoms to look out for after discharge was new or severe pain, fever, shortness of breath and unable to keep down fluids. Resident #59's oxygen requirements were three liters oxygen per minute via nasal cannula during the day and BIPAP overnight. Resident #59's BIPAP settings were 12/6. Encourage nightly BIPAP. Review of Resident #59's progress notes dated 06/22/25 at 8:00 P.M. revealed Resident #59 came back from the hospital via stretcher with EMS and was accompanied by her daughter. Resident #59's blood pressure was 117/65, pulse 91, respirations 17, temperature was 97.6 Fahrenheit, and her oxygen saturation was 98 percent on three liters of oxygen per minute via nasal cannula.Review of Resident #59's MAR and TAR dated 06/22/25 at 8:00 P. M. through 06/23/25 at 9:20 A.M. did not reveal evidence Resident #59 had BIPAP administered at 12/6 cmH20 with three liters oxygen at bedtime and as needed per physician orders. Review of Resident #59's medical record including progress notes, assessments, MAR and TAR dated 06/22/25 at 8:00 P.M. through 06/23/25 at 9:20 A.M. did not reveal evidence Resident #59 was monitored or assessed for fever, shortness of breath, lethargy, vital signs including respirations and oxygen saturation levels.Review of Resident #59's progress notes dated 06/23/25 at 9:20 A.M. revealed Registered Nurse/Unit Manager (RN/UM) #300 entered Resident #59's room to assist with getting Resident #59 up and ready for the day. Upon entering the room Resident #59 was observed sitting in her wheelchair with her eyes closed and her head down. RN/UM #300